The STANDARD INSURANCE

State of Arizona
Long Term Disability
Disability Claim Instructions

Standard Insurance Company, Employee Benefits Department
PO Box 2800 Portland OR 97208-2800 866.440.4846 Tel 800.378.6053 Fax

Welcome to Standard Insurance Company.

We realize that being disabled is difficult. Even though you are unable to work, your financial obligations don't go away. We at The Standard have prepared this claim packet to assist you with your application for Long Term Disability (LTD) benefits.

This packet contains the forms to apply for LTD benefits under the State of Arizona group policy. It also addresses common questions about benefit claims. **Please save this information for future reference.**

You may qualify for LTD benefits if you meet the terms of the LTD policy. LTD benefits through The Standard are provided for eligible employees in the following retirement plans:

- Public Safety Officers Retirement Plan
- Elected Officials' Retirement Plan
- Correctional Service Officers Retirement Plan
- Optional Retirement Plans of the universities (AIG, VALIC, Aetna, Fidelity, TIAA-CREF and Vanguard) and
- A Judge Pro Tempore, an employee in a medical residency program or a Cooperative Extension employee on federal appointment who by statute is not entitled to pension and isn't on per diem basis who is actively at work 20+ hrs/wk.

If you are an ASRS member, The Standard is not your LTD carrier. Please contact ASRS or your Benefit Liaison for information on how to file an LTD claim.

For specific information about your LTD insurance coverage, refer to your Certificate of Insurance. The group policy is ultimate authority for all claims decisions. If you do not have a Certificate of Insurance, you may obtain one at www.standard.com/mybenefits/arizona or by contacting your Benefit Liaison.

Your application for benefits consists of three forms. Every space on these forms should be filled in to avoid delay in processing your application. If a section does not apply, or information is not available, "NONE" should be written in the space so that we know you did not overlook the particular question. **If a form is received incomplete, it may be returned for completion. Each form must be completed and submitted to The Standard.** It is recommended that all these forms be submitted at the same time.

The three forms are:

1. **The Employee's Statement**

   - Answer every question completely. If a question does not apply to you, write "NA" and continue to the next question.
   - Use an additional page, if necessary, to give full and complete answers.
   - Attach copies of any Social Security, Public Employees Retirement System, Workers' Compensation or other benefit determinations you have received. If you have applied for any other benefits but have not yet received them, please send a copy of the application receipt. This information is needed to accurately calculate your monthly benefits. If you are unable to make copies of these documents please send the originals. We will photocopy and return them to you promptly.
   - Remember to sign and date your statement. **An unsigned or undated statement will be returned to you.**

2. **The Authorization to Obtain Information**
   The Authorization to Obtain Psychotherapy Notes

   - Please sign and date the Authorization to Obtain Information and attach it to the Employee's Statement. Your signature lets Standard Insurance Company (The Standard) get the information about you that we need to determine your eligibility for benefits. The Authorization to Obtain Information also lets The Standard release this information to specific persons.

     If you have seen or been treated by a Psychiatrist, Psychotherapist, Psychologist, Clinical Social Worker (MSW, MCSW, etc.), or any other provider of treatment for a mental condition, please sign and return the Authorization to Obtain Information ***and*** the Authorization to Obtain Psychotherapy Notes.

     You will receive copies of these Authorizations upon your request.

3. The Attending Physician's Statement

- **Part A** should be completed by you.
- **Part B** should be completed by your physician. **If you have seen more than one physician for your disability, a statement should be completed by each physician.** (You may request additional forms from your Benefit Liaison.) Your physician(s) should mail the completed form directly to The Standard.

You are responsible for making sure all required forms are completed and sent to our office. If you have questions about completing these forms, please contact your Benefit Liaison or The Standard.

You will be contacted by us no later than five working days from the date all completed forms are received in our office. In some cases, additional information may be needed to make a decision on your claim. If so, The Standard will provide details regarding the information needed.

Preexisting Conditions

If you have not been insured under the State of Arizona LTD policy for at least 12 months before becoming disabled, your claim may be subject to a "Preexisting Condition" clause. If you enrolled for disability coverage within the last 12 months, please list all physicians you have seen over the last three years on your claim form or another sheet of paper.

For LTD, benefits are not payable for Disability caused or contributed to by a Preexisting Condition. However, you may remain eligible for Life Waiver of Premium.

Other Benefits that May Reduce Your Disability Benefits

Other benefits you receive may reduce the amount of Disability benefits due you. Your group insurance certificate lists these benefits, which may include, but are not limited to, sick leave, Workers' Compensation, Social Security, and Retirement.

To avoid a possible overpayment of your claim, please inform The Standard if you receive other benefits.

When You Return to Work

Your disability benefits usually stop when you return to work. **Be sure that you or your employer notify The Standard immediately when you plan to, or have, returned to work** to assure no overpayment occurs.

Payment of Benefits

LTD benefits are paid monthly at the end of the monthly benefit period. The due date of your check is determined by your date of disability.

For Additional Information

If you have questions regarding your LTD or Life Waiver of Premium, or are interested in options for continuing coverage when you are no longer a Member, please call 866.440.4846. You can also access additional information, including your Certificates of Insurance that contain detailed descriptions of coverages including definitions, exclusions, limitations, restrictions, and terminating events, by going to www.standard.com/mybenefits/arizona. Your Benefits Liaison is also available to assist you.

Reset

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PO Box 2800 Portland OR 97208-2800 866.440.4846 Tel 800.378.6053 Fax

State of Arizona – Long Term Disability Employee Statement

TO BE COMPLETED BY EMPLOYEE

1. Full Name _____ Phone No. (_____) _____

Address _____

City _____ State _____ Zip Code _____

Birth Date _____ Social Security number _____ Sex _____ Male _____ Female

Name of Spouse _____ No. of dependent children under age 25 _____ Birthdate of youngest _____

Agency Name _____ Supervisor Name _____ Phone No. (_____) _____

2. Long Term Disability

In order to qualify for Long Term Disability with The Standard, you must be a member of one of the following retirement plans or programs. Please select the program in which you participate.

- ☐ Public Safety Officers Retirement Plan
- ☐ Elected Officials' Retirement Plan
- ☐ Correctional Service Officers Retirement Plan
- ☐ Optional Retirement Plans of the universities (AIG, VALIC, Aetna, Fidelity, TIAA-CREF and Vanguard)
- ☐ A Judge Pro Tempore, an employee in a medical residency program or a Cooperative Extension employee on federal appointment who by statute is not entitled to pension and isn't on per diem basis who is actively at work 20+ hrs/wk.

If you are a member of ASRS, The Standard is not your Long Term Disability carrier. Please contact ASRS or your Benefits Liaison to initiate a Long Term Disability claim.

3. State your job title and your duties at work (attach separate page if needed) _____

Is your disability work related? ☐ Yes ☐ No Have you filed a Workers' Comp. claim? ☐ Yes ☐ No Do you intend to file? ☐ Yes ☐ No

If you have filed a Workers' Comp. claim, please list claim number _____

Last day of work _____ Date you became unable to work at your occupation _____

Are you now working for any employer or self-employed? ☐ Yes ☐ No If yes, please list the name, address and phone number of the employer on a separate piece of paper and attach to this form or provide details of your self-employment.

Date you resumed full-time work _____ or part time work _____

Did you receive a certificate of insurance or summary plan description? ☐ Yes ☐ No If no, please contact your agency to obtain a copy.

4. Nature of illness/accident _____

Date first noticed _____ What do you believe caused your disability? (include the time, date and location of accident) _____

Explain how your illness/injury prevents you from working _____

Have you ever had the same condition or a related illness before? ☐ Yes ☐ No

5. Pregnancy: Expected delivery date _____ Actual delivery date _____

Type of delivery (if known): ☐ Vaginal ☐ C-Section Expected return to work date _____

VOCATIONAL *Complete the following and/or attach a resume.*

6. Education level	Yes	No	If no, last grade attended.	
Grade School Graduate	☐	☐		
High School Graduate	☐	☐		
GED	☐	☐		
College Graduate	☐	☐	Degree	Major
Post Graduate	☐	☐	Degree	Major

Have you attended any trade schools or received other special training? ☐ Yes ☐ No
If yes, please describe.

Work Experience: *Complete the following for the last 10 years, starting with your most recent work experience.*

Job Title & Employer	Dates of Employment	Duties	Last Salary
1.	From: To:		
2.	From: To:		
3.	From: To:		

7. Please list any professional licenses you have obtained (Real Estate, Teaching Cert., Pilots, etc.) Are they current? ☐ Yes ☐ No

Do you now have a valid driver's license? ☐ Yes ☐ No Chauffer's license? ☐ Yes ☐ No Commercial? ☐ Yes ☐ No

Are you or have you been engaged in a vocational retraining program? ☐ Yes ☐ No

If yes, please list participation dates _____ through _____

Is a counselor assisting you with your job search? ☐ Yes ☐ No If yes, please complete the following.

Counselor's name: _____ Type of program: _____

Firm/agency name: _____

Address: _____ Phone No.: (___) _____ Fax No.: (___) _____

8. Physician's Name _____ Date first consulted for this injury or illness _____

Street Address _____ City _____ State _____ Zip Code _____

Phone No. (_____) _____

List all other medical professionals consulted within the past three years. ***(continue on a separate page if necessary)***

1. _____ (_____) _____ _____
Name Phone No. Date first consulted

2. _____ (_____) _____ _____
Name Phone No. Date first consulted

If you were hospitalized within the past three years, please complete.

Hospital Name and Address _____

From _____ Through _____ Reason for hospitalization _____

From _____ Through _____ Reason for hospitalization _____

OFFSETS

9. Have you applied for or have you received benefits from:

	Applied Yes	Applied No	Receiving Yes	Receiving No	Date of Application	Amount Weekly	Amount Monthly	Effective Date
a. Sick Leave/Donated Leave	☐	☐	☐	☐				
b. Social Security	☐	☐	☐	☐				
c. Workers' Compensation	☐	☐	☐	☐				
d. Any other Group Disability Plans	☐	☐	☐	☐				
If yes, name of carrier: _____								
e. Retirement/Pension/ASRS	☐	☐	☐	☐				
Please specify type: _____								
f. Other _____ (e.g. unemployment or union benefits)	☐	☐	☐	☐				

10. Please send copies of any letters or notices approving or denying benefits to allow us to calculate your benefits from The Standard.

Acknowledgement

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice below.

Signature _____ Date _____

CLAIM FORM FRAUD NOTICE

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

The STANDARD INSURANCE

State of Arizona
Long Term Disability
Authorization to Obtain Information

Standard Insurance Company, Employee Benefits Department
PO Box 2800 Portland OR 97208-2800 866.440.4846 Tel 800.378.6053 Fax

I AUTHORIZE THESE PERSONS having any records or knowledge of me or my health:

- Any physician, medical practitioner or health care provider.
- Any hospital, clinic, pharmacy or other medical or medically related facility or association.
- Any insurance company.
- Any employer or plan sponsor.
- Any organization or entity administering a benefit program.
- Any educational, vocational or rehabilitational organization or program.
- Any consumer reporting agency, financial institution, accountant, or tax preparer.
- Any government agency (*for example, Social Security Administration, Public Retirement System, Railroad Retirement Board, etc.)*

TO GIVE THIS INFORMATION:

- Charts, notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing and test results. Prognosis and treatment of any physical or mental condition, including:
  - Any disorder of the immune system, including HIV, Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes.
  - Any communicable disease or disorder.
  - Any psychiatric or psychological condition, including test results, but excluding psychotherapy notes. Psychotherapy notes do not include a summary of diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date.
  - Any condition, treatment, or therapy related to substance abuse, including alcohol and drugs.

  and:
- Any non-medical information requested about me, including such things as education, employment history, earnings or finances, or eligibility for other benefits (*for example, Social Security Administration, Public Retirement System, Railroad Retirement Board, claims status, benefit amounts and effective dates, etc.).*

TO STANDARD INSURANCE COMPANY.

- I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct the persons and organizations identified above to release and disclose my entire medical record without restriction. I understand that The Standard will use the information to determine my eligibility or entitlement for insurance benefits.
- I understand and agree that this authorization shall remain in force throughout the duration of my claim for benefits with The Standard. I understand that I have the right to refuse to sign this authorization and a right to revoke this authorization at any time by sending a written statement to The Standard, except to the extent it has been relied upon to disclose requested records. A revocation of the authorization, or the failure to sign the authorization, may impair The Standard's ability to evaluate or process my claim and may be a basis for denying my claim for benefits.
- I understand that in the course of conducting its business, The Standard may disclose to other parties information it has about me. The Standard may release this information about me to a reinsurer, a plan administrator, or any person performing business or legal services for The Standard in connection with my claim.
- I understand that The Standard complies with state and federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to The Standard pursuant to this authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by law. (Disability coverage is not subject to the Privacy Rules of the Health Insurance Portability and Accountability Act (HIPAA) and therefore the release of information to The Standard is not protected under the Act.)
- I acknowledge that I have read the authorization and the state variations *(if applicable)* on the following page. A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

Name *(please print)* _____ Social Security No. _____

Signature of Claimant/Guardian/Representative _____ Date _____

If signature is provided by Attorney in Fact, please attach a copy of Power of Attorney.

This Authorization is a two-page document. Please see page 6 for additional terms and information. Both pages are part of the Authorization.

Standard Insurance Company, Employee Benefits Department
PO Box 2800 Portland OR 97208-2800 866.440.4846 Tel 800.378.6053 Fax

Some states require us to provide the following information to you and to those persons and entities disclosing information about you:

FOR RESIDENTS OF MINNESOTA

This authorization excludes the release of information about HBV (Hepatitis B Virus), HCV (Hepatitis C Virus), or HIV (Human Immunodeficiency Virus) tests which were administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "emergency medical personnel" includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or to other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards, at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the good samaritan law.

FOR RESIDENTS OF NEW MEXICO

The state of New Mexico requires us to provide you with the following information pursuant to its Domestic Abuse Insurance Protection Act.

The accompanying Authorization to Obtain Information allows Standard Insurance Company to obtain personal information as it determines your eligibility for insurance benefits. The information obtained from you and from other sources may include confidential abuse information. "Confidential abuse information" means information about acts of domestic abuse or abuse status, the work or home address or telephone number of a victim of domestic abuse or the status of an applicant or insured as a family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close personal, family or abuse-related counseling relationship. With respect to confidential abuse information, you may revoke this authorization in writing, effective ten days after receipt by The Standard, understanding that doing so may result in a claim being denied or may adversely affect a pending insurance action.

The Standard is prohibited by law from using abuse status as a basis for denying, refusing to issue, renew or reissue or canceling or otherwise terminating a policy, restricting or excluding coverage or benefits of a policy or charging a higher premium for a policy.

Upon written request you have the right to review your confidential abuse information obtained by The Standard. Within 30 business days of receiving the request, The Standard will mail you a copy of the information pertaining to you. After you have reviewed the information, you may request that we correct, amend or delete any confidential abuse information which you believe is incorrect. The Standard will carefully review your request and make changes when justified. If you would like more information about this right or our information practices, a full notice can be obtained by writing to us.

If you wish to be a protected person (a victim of domestic abuse who has notified The Standard that you are or have been a victim of domestic abuse) and participate in The Standard's location information confidentiality program, your request should be sent to the same address above.

The STANDARD INSURANCE

State of Arizona
Long Term Disability
Authorization to Obtain Psychotherapy Notes

Standard Insurance Company, Employee Benefits Department
PO Box 2800 Portland OR 97208-2800 866.440.4846 Tel 800.378.6053 Fax

I AUTHORIZE THESE PERSONS having any records or knowledge of me or my health:

- Any physician, medical practitioner or health care provider; and
- Any hospital, clinic, or other medical or medically related facility or association.

TO GIVE THIS INFORMATION:

Notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation(s) during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of my medical record.

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- I understand and agree that this authorization shall remain in force throughout the duration of my claim for benefits with The Standard. I understand that I have the right to refuse to sign this authorization and a right to revoke this authorization at any time by sending a written statement to The Standard, except to the extent it has been relied upon to disclose requested records. A revocation of the authorization, or the failure to sign the authorization, may impair The Standard's ability to evaluate or process my claim and may be a basis for denying my claim for benefits.
- I understand that in the course of conducting its business, The Standard may disclose to other parties information it has about me. The Standard may release this information about me to a reinsurer, a plan administrator, or any person performing business or legal services for The Standard in connection with my claim.
- I understand that The Standard complies with state and federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to The Standard pursuant to this authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by law. (Disability coverage is not subject to the Privacy Rules of the Health Insurance Portability and Accountability Act (HIPAA) and therefore the release of information to The Standard is not protected under the Act.)
- I acknowledge that I have read the authorization and the state variations (if applicable) on the following page. A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

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Upon written request you have the right to review your confidential abuse information obtained by The Standard. Within 30 business days of receiving the request, The Standard will mail you a copy of the information pertaining to you. After you have reviewed the information, you may request that we correct, amend or delete any confidential abuse information which you believe is incorrect. The Standard will carefully review your request and make changes when justified. If you would like more information about this right or our information practices, a full notice can be obtained by writing to us.

If you wish to be a protected person (a victim of domestic abuse who has notified The Standard that you are or have been a victim of domestic abuse) and participate in The Standard's location information confidentiality program, your request should be sent to the same address above.

The STANDARD SM INSURANCE

State of Arizona
Long Term Disability
Attending Physician's Statement

Standard Insurance Company, Employee Benefits Department
PO Box 2800 Portland OR 97208-2800 866.440.4846 Tel 800.378.6053 Fax

PART A. TO BE COMPLETED BY EMPLOYEE (PATIENT)

Please type or print. The patient is responsible for the completion of this form without expense to Standard Insurance Company.

Full Name _____ Social Security No. _____

Employer **State of Arizona** Agency _____ Policy No. **617950**

Phone No. (_____) _____ Medical Plan _____ Patient No. _____

PART B. TO BE COMPLETED BY PHYSICIAN

The following information is needed to document the Patient's inability to work:

1. Diagnosis

A. Primary Diagnosis _____ ICDA Classification _____

B. Secondary Diagnosis (related to patient's disability) _____

C. Symptoms _____

D. Objective findings _____

E. Patient's height _____ Weight _____ Most recent blood pressure: Systolic: _____ Diastolic: _____ Pulse: _____

2. Pregnancy (If Applicable)

Expected date of delivery _____ Anticipated to be normal? ☐ Yes ☐ No

Para _____ Gravida _____ Abortion _____

Actual date of delivery _____ Type of delivery: ☐ Vaginal ☐ Caesarean Section

3. History

A. When did symptoms appear ? _____

B. Is condition the result of an accidental injury? ☐ Yes ☐ No If yes, describe accident: _____

C. Did you recommend the patient stop work? ☐ Yes ☐ No

If yes, as of what date? _____

Why? _____

If no, who recommended that the patient stop work? _____

D. Has the patient ever had the same or similar condition? ☐ Yes ☐ No If yes, when? _____

Describe _____

E. Is the condition related to

a. Patient's Employment? ☐ Yes ☐ No ☐ Undetermined
b. Mental Disorder? ☐ Yes ☐ No ☐ Undetermined
c. Alcohol or Drug Condition? ☐ Yes ☐ No ☐ Undetermined

F. Did you complete a Workers' Compensation Report for this condition? ☐ Yes ☐ No

4. Treatment

A. Date of first visit _____ Date of most recent visit _____

B. Date of subsequent visits _____

C. Planned course of treatment (Include surgery, physical therapy, psychiatric counseling.) _____

Current medications (Include dosage and frequency): _____

5. Cardiac classification (If Applicable)

A. Functional classification (American Heart Association) ☐ Class I ☐ Class II ☐ Class III ☐ Class IV

B. Therapeutic classification ☐ Class A ☐ Class B ☐ Class C ☐ Class D ☐ Class E

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6. Physical Capacities

Based upon objective findings, please indicate below the amount of activity this individual can tolerate in a work day, for **any** employer. Indicate the functional capacities of this individual given two breaks, positional changes, and meal break(s).

Person can:	1 Hr.	2 Hrs.	3 Hrs.	4 Hrs.	5 Hrs.	6 Hrs.	7 Hrs.	8 Hrs.	9 Hrs.	10 Hrs.	11 Hrs.	12 Hrs.	NOT AT ALL	Total Wrk. Day Hrs.	Duration of Restriction PERM.	TEMP.	DURATION
a. Sit	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____	☐	☐	_____
b. Stand	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____	☐	☐	_____
c. Walk	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____	☐	☐	_____

Bend/Stoop: ☐ Never ☐ Occasionally ☐ Frequently Dominant Hand: ☐ Right ☐ Left

What assistive devices are currently in use? _____

NOTE: In terms of a work day: "OCCASIONALLY" = 1% - 33%; "FREQUENTLY" = 34% - 66%; "CONTINUOUSLY" = 67% - 100%

	OCCASIONALLY			FREQUENTLY			CONTINUOUSLY		
Individual can:	**Lift**	**Carry**	**Push/Pull**	**Lift**	**Carry**	**Push/Pull**	**Lift**	**Carry**	**Push/Pull**
1-10 lbs.									
11-20 lbs.									
21-50 lbs.									
51-75 lbs.									
76-100 lbs.									

Are there any limitations on the patient's ability to do repetitive upper extremity activities? Please describe. _____

Specifically: fingering, reaching and grasping? _____

Specifically: ability to do overhead lifting or overhead reaching? _____

7. Level of Functional Impairment

A. The patient is: ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospital Confined

B. Other impairments (please be specific) _____

C. Describe the patient's mental and cognitive limitations and restrictions _____

D. **Is this patient competent to endorse checks and direct the use of the proceeds?** ☐ **Yes** ☐ **No**

8. Hospitalization

A. Date admitted _____ Date discharged _____ Date surgical procedure performed _____

B. Reason for admittance to hospital _____

C. Describe nature of any surgical procedure performed _____

Name of hospital _____

Address _____ City _____ State _____ Zip _____

9. Other treating medical professionals (if known)

A. Name _____ Specialty _____ Phone No. (_____) _____

Address _____ City _____ State _____ Zip _____

B. Name _____ Specialty _____ Phone No. (_____) _____

Address _____ City _____ State _____ Zip _____

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10. Prognosis

A. Describe patient's condition since onset of symptoms: ☐ Recovered ☐ Improved ☐ Not Changed ☐ Retrogressed

B. When do you expect a fundamental or marked change in the patient's condition? _____

☐ Unable to determine, follow up in _____ weeks _____ months. ☐ Never

C. When do you anticipate the patient can return to work?

_____ Full-time _____ Part-time (_____ hrs/day, _____ days/weeks)

☐ Unable to determine, follow up in _____ weeks _____ months. ☐ Never

Name of Physician completing this form (Please type or print.) _____ Specialty _____

Address _____ City _____ State _____ Zip _____

Phone No. (_____) _____ Taxpayer Identification No. _____

Acknowledgement

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice below.

Signature _____ Fax No. _____ Date _____

Please send copies of chart notes, diagnostic, laboratory, and electrodiagnostic findings, as well as operative reports and hospital discharge summaries for the past year.

Return to: Standard Insurance Company
Employee Benefits Department
P.O. Box 2800
Portland, OR 97208-2800

CLAIM FORM FRAUD NOTICE

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

Print